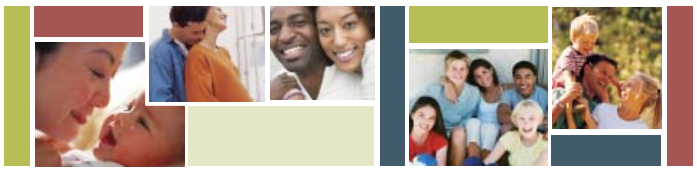
THE UPdate



The Update is a bi-weekly web newsletter published by the Iowa Department of Public Health's Bureau of Family Health. It is posted the second and fourth week of every month, and provides useful job resource information for departmental health care professionals, information on training opportunities, intradepartmental reports and meetings, and additional information pertinent to health care professionals.

In this issue...

The Case for Investing in Youth Health Literacy

One step on the path to achieving health equity for adolescents

The health literacy of adolescents is a significant concern, especially as teens are increasingly accessing health information online and the credibility of this information is largely unknown. In celebration of Health Literacy Month, the National Institute of Health Care Management Foundation has released an issue brief, *The Case for Investing in Youth Health Literacy: One Step on the Path to Achieving Healthy Equity for Adolescents*, which discusses opportunities for health plans and foundations to potentially reduce future health care spending by investing in programs and initiatives to improve health literacy during adolescence, a critical developmental period when many health behaviors are initiated.

This issue brief shares recent strategies proposed by the federal government to achieve health equity and improve health literacy, including specific strategies relevant to health plans and foundations. The brief also highlights several examples of current health plan and health plan foundation efforts to improve adolescent health literacy.

The issue brief can be downloaded from pages 8-23 of **The UPdate**.

For additional resources on maternal, child and adolescent health issues, please visit NIHCM Foundations's MCAH Publications and Conferences and Webinars pages.

Free Online Course - CEUs and CHES credits available

Unified Health Communication (UHC): Addressing Health Literacy, Cultural Competency, and Limited English Proficiency is free, on-line, go-at-your-own-pace training that has helped more than 4,000 health care professionals and students improve patient-provider communication.

Take the course any time, night or day, to improve your ability to communicate with patients and overcome barriers that can keep patients from taking their medications according to your instructions, going to the emergency room when they would be better served in primary care or otherwise preventing them from getting the full benefit of the quality care you provide.

Medically underserved patients may have particular difficulty communicating with their health care providers. If you treat patients who are low income, uninsured, and/or whose English proficiency is low, this course will help you meet your clients needs.

For registration information, go to www.hrsa.gov/publichealth/healthliteracy/index.html.

2012 Governor's Conference on Public Health

Planning for the 2012 Governor's Conference on Public Health is already well underway! This exciting event strives to bring together national and local experts to present the latest trends in public health in an effort to prevent disease and promote health. The event will be held April 17 & 18 at the Scheman Center in Ames.

While the abstract process for selecting concurrent sessions is currently in progress, the plenary speakers have all be secured. It is with much excitement that we announce that **Emily Friedman** will be opening the conference with a discussion on health care reform and the public health connection. Emily is a consultant on information dissemination to the Agency for Health Care Research and Quality, U.S. Department of Health and Human Services. She also serves as adjunct assistant professor of bioethics , Department of Health Law, Bioethics, and Human Rights at the Boston University School of Public Health. She is most noted for her work in health policy, health care trends, health insurance and managed care, the social ethics of health care, health care for the underserved, health care history, population demographics, and the relationship of the public with the health care system.

The second day of the conference will highlight **Dr. Richard Jackson**, who has done extensive work on the impact of the environment on health, particularly relating to children. Dr. Jackson chaired the American Academy of Pediatrics Committee on Environmental Health. He did extensive work on pesticides in California, and has also focused on how the 'built environment' including how architecture and urban planning affect health. Currently, Dr. Jackson has been working on policy analyses of environmental impacts on health ranging from toxicology, chemical body burdens, terrorism, sustainability, climate change, urban design and architecture. In addition, he is developing policy analyses in related areas, such as how farm, education, housing and transportation policies affect health.

continued on next page

2012 Governor's Conference on Public Health
continued

Rob Bell will close the conference with a presentation that promises to be energetic and entertaining - yet has some applicable skill-building tips. Rob began teaching early in his tenure as Personnel Development and Education & Training Director for Dick's Supermarkets, Inc. His presentations will inspire your organization to reach a new level of customer service, increase positive leadership while polishing important internal and external communication skills. His style is fun, engaging, thought-provoking and unforgettable.

The Governor's Conference on Public Health is planned by a group of partners, including: Child Health Specialty Clinics, Iowa Counties Public Health Association, Iowa Department of Public Health, Iowa Environmental Health Association, Iowa Public Health Association, State Hygienic Laboratory at the University of Iowa, and University of Iowa College of Public Health. Over 500 public and environmental health professionals are expected to attend the 2-day conference. Information on how to register for the conference will be made available soon through the IPHA website at www.iowapha.org.

We hope you can join us to be part of this important public health event in Iowa!

Request for Membership to Complete Iowa Survey on Developmental Screening in Medical Practices

The Bureau of Family Health would like to hear from maternal/child health agencies to more fully understand developmental practices in Iowa. The Iowa Chapter of the American Academy of Pediatrics, sponsored by Iowa's Project LAUNCH Initiative, is conducting a survey on developmental screening in a variety of patient care settings.

The questionnaire takes about 10 minutes to complete. Information provided will contribute to a statewide analysis on integrating developmental screening into patient care and practice recommendations. Results will be shared with Iowa association chapters and other interested respondents after the close of the survey, scheduled for October 30, 2011.

Responses from a variety of child health related medical practitioners is optimal, therefore we would greatly appreciate you forwarding this survey to other medical professionals and associations.

To complete the survey, click on the following link: www.surveymonkey.com/s/Iowadevelopmentalscreeningsurvey.

Oral Health Recent Events

News from the Bureau of Oral and Health Delivery Systems - Oral Health Center

School-Based Sealant Program Retention Checks
The Oral Health Center recently sent guidance for completing retention checks to agencies who participate in the IDPH-funded School-Based Sealant Program. The purpose of retention checks is to assess the quality of sealant placement techniques by checking that sealants are still present or not needing repair.

In addition to IDPH guidance, a Seal America document is an additional reference for more information on how and why retention checks should be made: www.mchoralhealth.org/seal/step10.html.

If your agency implements a dental sealant program with I-Smile™ or other funding, this is a quality assurance measure that you should consider as well. For more information, please contact Heather Miller at heather.miller@idph.iowa.gov or (515) 281-7779.

2010-2011 School Dental Screening Audit Report
The 2010-2011 school year was the third year of implementation of Iowa's school dental screening requirement. The law requires that all children newly-enrolling in kindergarten or ninth grade in an Iowa public or accredited non-public elementary or high school provide proof of a dental screening.

Some key data from the Iowa Department of Education included:

- 81,575 students were enrolled in kindergarten and 9th grade
- Usable audit data was submitted for 54,709 students totaling 67.1 percent student compliance rate
- Student compliance data was submitted for 1,160 schools totaling 88.4 percent school compliance rate

The 1,160 schools included in the 2010-2011 audit report detailed:

- 73.2 percent of students submitted a valid certificate
- 15.5 percent of students had treatment needs
- 69.0 percent of students were screened by a dentist
- 24.8 percent of students were screened by a dental hygienist
- 5.1 percent of students were screened by a nurse
- 1.1 percent of students were screened by a physician or physician assistant

The full comprehensive school dental screening report can be found at www.idph.state.ia.us/hpcdp/oral_health_school_screening.asp.

Administration/Program Management

IME Informational Letter #1062: - Important HIPAA Transition Information
Important for all Medicaid Members Billing Electronically!

The Iowa Medicaid Enterprise has issued Informational Letter #1062 reminding Medicaid providers that the Version 5010 transition ***is less than three months away!*** **On January 1, 2012 all electronic claims submitted to IME must be in Version 5010 format**. This means that **all covered entities submitting electronic transactions must upgrade to Version 5010**. Version 5010, unlike the current Version 4010, is required for the use of the new ICD-10 medical codes sets.

To ensure that there is no disruption of claim submissions on January 1, 2012, the Iowa Medicaid's Electronic Data Interchange Support Services (EDISS) encourages all providers to enroll in Total OnBoarding (TOB) (5010 HIPAA format) well before the January 2012 deadline. If the TOB profile has not been enrolled for Version 5010 by this date, the provider will no longer be able to submit electronic transactions. At that time, the current 4010 format will be deleted from the EDISS system.

How to Transition to the 5010 Format
Guidelines for transition to the 5010 format in the form of a checklist are found on the EDISS website at www.edissweb.com/docs/shared/5010_checklist.pdf. The checklist is organized into 3 sections:

- Direct Providers not using PC-ACE Pro32
- Direct Providers using PC-ACE Pro32
- Providers sending files through a clearinghouse or billing service

To begin preparation for the transition, follow the section of the guidelines that is applicable to your agency.

EDISS will work closely with providers to ensure that all activities from claim submission to payment occur accurately. Providers are encouraged to enroll in Version 5010 ***well in advance of*** the January 1, 2012 date to assure that the process is working smoothly.

See Informational Letter #1062 on pages 24-25 of **The UPdate** for further detail. Information is also available at www.cms.gov/ICD10 which provides the latest news and resources to help you prepare for the transition to both the 5010 format and ICD-10 codes. If you have questions, please contact IME Provider Services at 1-800-338-7909 (in the Des Moines area at 515-256-4609) or by email at imeproviderservices@dhs.state.ia.us.

Bureau of Family Health Grantee Committee Meeting

Information presented at the October 6, 2011 Bureau of Family Health Grantee Committee meeting is available on pages 26-53 of The Update. The next meeting will be held via the ICN on January 19, 2012. *This is a required meeting for Bureau of Family Health - MCH/FP contract agencies*.

Calendar

November 15-16

Domestic Violence & Reproductive Coercion for Home Visitation Programs Training
Polk County River Place Conference Center
Room 1-1A

*January 19, 2012

Bureau of Family Health Grantee Committee Meeting
ICN

* Required meeting

NOVEMBER Contract Required Due Dates

14 - FP Client Visit Records

15 - Electronic Expenditure Workbooks

15 MCH FP Summary of Insurance Verification

15 MCH/FP Year-End Report (including MCH/FP Client Satisfaction Survey & FP Outreach Report)

28 Export WHIS Records to IDPH

30 2011 Semi-Annual CAReS/WHIS Review Summaries

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Healthy Families Line: 1-800-369-2229
FAX: 515-242-6013

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THE CASE FOR INVESTING IN YOUTH HEALTH LITERACY:

ONE STEP ON THE PATH TO ACHIEVING HEALTH EQUITY FOR ADOLESCENTS

NIHCM FOUNDATION

NIHCM FOUNDATION ISSUE BRIEF
OCTOBER 2011

INTRODUCTION

The adolescent population is becoming more diverse than the general population.

The population of adolescents in the U.S. is growing and is now more racially/ethnically diverse than the general population. This diversity is only expected to increase as the percentage of white, non-Hispanics in the adolescent population is estimated to drop from 62.9 percent in 2000 to 55.8 percent by 2020.[1] Minority adolescents are more likely to live in urban areas and experience poverty at a higher rate than their peers.[2] All of these factors point to widening health care inequities for the adolescent population in the U.S. Healthy People 2020 specifically draws attention to the impact this rapidly growing ethnic diversity will have on adolescent health in the decade ahead and calls for cultural and linguistic responsiveness to health care needs and sharpened attention to the disparate health and academic outcomes correlated with poverty among minority adolescents.[3]

Adolescence is an important developmental time period.

Adolescence is a critical time period to arm youth with current, accurate health information and ensure they have an opportunity to grow up in healthy and safe communities. Adolescence is characterized by the beginning of a shift to independent behavior and decision making and may be the first time that individuals begin to think about how their identity affects their lives.[4] While adolescents are generally healthy, research suggests that the health behaviors developed during this period impact the risk for future chronic disease as adults.[5] For example, cigarette smoking, which usually begins by age 18, leads to chronic conditions in adulthood with an estimated annual financial burden of $193 billion.[6]

Access to insurance coverage is a necessary but not sufficient step to eliminating health disparities.

Achieving health equity for adolescents requires both the elimination of health disparities and provision of adolescent-friendly services to allow all adolescents a fair opportunity to attain their full health potential.[7] Insured adolescents experience fewer disparities in access to health care, and the Affordable Care Act (ACA) contains numerous provisions to increase the opportunities for adolescents to obtain health insurance coverage.[8] According to 2009 Current Population Survey (CPS) data, 60 percent of adolescents aged 12-17 years old were enrolled in private insurance coverage, 29 percent were enrolled in Medicaid or other government programs, and 11 percent were uninsured.[9] The ACA will largely maintain access to coverage for adolescents who are privately insured, and new outreach and enrollment efforts are expected to improve public coverage for adolescents already eligible for Medicaid and the Children's Health Insurance Program but not enrolled. In addition, if the individual mandate provision of the ACA is implemented, in 2014 parents will be required to obtain coverage for their children if they are not insured, which could potentially lead to three million uninsured children and adolescents gaining health insurance coverage.[10]

However, gains in coverage alone will not eliminate disparities in access to care, and concerns remain about adolescents' access to equitable health care once insured. Access to providers will continue to vary depending on where the adolescents reside and whether they are enrolled in public or private coverage. In fact, a recent study recognized that children enrolled in Medicaid are more likely than those with private insurance to be turned away by medical specialists or wait more than a month for an appointment.[11] Additionally, access to providers specifically trained in adolescent medicine will impact the quality of the health care services received by adolescents. Access to adolescent specialists is severely limited since these practitioners are commonly available only in academic health centers.[12] Adolescents may also continue to face uncertainties regarding their access to equitable health care, even after they are insured. Recent research found that income fluctuations may lead to the movement of millions of adults and their families between Medicaid and subsidized coverage through the state exchanges, often within months of their initial enrollment in the programs. For adolescents, a shift from Medicaid to exchange coverage may result in a major loss of benefits, unless private coverage is required to meet the standard of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment benefit.[13]

Improving health literacy is also key to eliminating health disparities.

The capacity to obtain, process and understand basic health information and services, known as health literacy, affects a person's ability to make appropriate health decisions and adopt healthy behaviors. While limited health literacy disproportionately affects lower socioeconomic and minority groups, it is widespread across the population regardless of age, education level, income or race.[14] One study has estimated that the cost of limited health literacy across the U.S. population is between $106 and $236 billion dollars annually.[15] Health literacy among students is a significant concern: 7,000 students drop out of school each day – 1.2 million each year – and even among students who remain in school, there is a lack of consistent health curricula across grades K-12 that may result in low levels of student health literacy.[16] Individuals with adequate or high levels of health literacy enjoy better overall health outcomes than those with limited health literacy; thus, empowering adolescents with the skills to communicate effectively about their health and understand health care issues and the health care system is a critical factor in eliminating health inequities for this population.

So, what can health plans do to promote health equity and health literacy?

Health plans and health plan foundations have an opportunity to promote health equity and potentially reduce future health care spending by investing in programs and initiatives to improve adolescent health literacy. This issue brief will explore recent strategies proposed by the federal government to eliminate disparities and work toward health equity, including specific strategies relevant to health plans and foundations. We then summarize recent research on where adolescents access health information, the credibility of this information, and their comprehension of the information. We conclude by sharing several examples of current health plan and health plan foundation efforts to improve adolescent health literacy.

FEDERAL STRATEGIES THAT IDENTIFY ROLES FOR HEALTH PLANS AND FOUNDATIONS IN PROMOTING ADOLESCENT HEALTH LITERACY

The National Partnership for Action to End Health Disparities (NPA) is a community-driven initiative supported by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health to increase the effectiveness of policies and programs that target the elimination of health disparities by fostering collaboration among public and private sector stakeholders.[17] In April 2011 the NPA launched the *National Stakeholder Strategy for Achieving Health Equity* (NSS), which outlines specific strategies that organizations can adopt to help racial and ethnic minorities and other underserved groups, including adolescents, reach their full health potential. In addition to this report, HHS previously released the *National Action Plan to Improve Health Literacy* in May 2010, which offers strategies to make health information and services easier to use and understand by creating health and safety information that is accurate,

accessible and actionable. Both of these reports recognize that health plans are essential partners in achieving health equity and promoting health literacy among adolescents. The following section shares the four most relevant recommendations from each of these reports that can be implemented by health plans and health plan foundations.

National Stakeholder Strategy for Achieving Health Equity[18]

Goal 1. AWARENESS – Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic and underserved populations. Health plans and health plan foundations can support this goal by:

- Partnering with other private and public organizations to form an infrastructure that will increase awareness, ensure accountability and drive action toward eliminating health disparities among adolescents;
- Using and creating communication tools designed for adolescents that will present varied views of the consequences of health disparities and that will encourage them to act and invest in their health and the health of their peers; and
- Utilizing local, regional and national media outlets and information technology to reach adolescents to encourage them to make healthy decisions.

Goal 2. LEADERSHIP – Strengthen and broaden leadership for addressing health disparities at all levels. Health plans and health plan foundations can support this goal by:

- Soliciting community input on funding priorities; and
- Investing in adolescents and young adults to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness and safety initiatives.

Goal 3. HEALTH SYSTEM AND LIFE EXPERIENCE – Improve health and health care outcomes for racial, ethnic and underserved populations. Health plans and health plan foundations are uniquely suited to improve health outcomes for underserved populations, including adolescents, by:

- Ensuring the provision of needed services (e.g., mental, oral, vision, hearing and physical health; nutrition; and services related to the social and physical environments) for at-risk children and adolescents, including those in out-of-home care;
- Enhancing and improving health service experience through improved health literacy, communications and interactions and;
- Working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits.

Goal 4. CULTURAL AND LINGUISTIC COMPETENCY – Improve cultural and linguistic competency and the diversity of the health-related workforce. Health plans are well-positioned within the health care system to have an impact on the achievement of this goal by:

- Developing and supporting the health workforce and related industry workforces through the promotion of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities;
- Increasing diversity and competency of the health workforce and related industry workforces through recruitment, retention and training of racially, ethnically and culturally diverse individuals and through leadership action by health care organizations and systems; and
- Encouraging interpreters, translators and bilingual staff who provide services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation, and encouraging financing and reimbursement for health interpreting services.

National Action Plan to Improve Health Literacy[19]

Organizations can use the *National Action Plan to Improve Health Literacy* (NAPHL) as a blueprint to create their own unique health literacy plan that is ideally suited to the individuals they serve. Health plans are identified in this action plan as important partners in achieving a health literate society; below we highlight four goals and their adapted strategies that are particularly relevant to plans and foundations.

GOAL 1: DEVELOP AND DISSEMINATE HEALTH AND SAFETY INFORMATION THAT IS ACCESSIBLE AND ACTIONABLE – Health plans can play an active role in reaching this goal by:

- Engaging staff in ongoing training in health literacy;
- Including members of the target population in the planning, development, implementation, dissemination and evaluation of health information and education materials;
- Using technology and e-health tools to deliver health information and services when, where and how children and adolescents want and need them;
- Supporting and participating in media and information literacy projects;
- Reviewing and analyzing existing laws, policies and regulations that make all types of health information (e.g., general health, safety, medication, health care coverage, financing, and informed consent) difficult to use; and
- Developing and applying metrics that assess the results from health literacy efforts.

GOAL 2: PROMOTE CHANGES IN THE HEALTH CARE DELIVERY SYSTEM THAT IMPROVE HEALTH INFORMATION, COMMUNICATION, INFORMED DECISION MAKING AND ACCESS TO HEALTH SERVICES – Health plans and foundations have the ability to promote changes in the health care delivery system by:

- Creating an environment where health literacy is not assumed but has been infused as part of the organizational mission and operating philosophy; [20]
- Integrating health literacy and cultural competency into audit tools, standards and scorecards related to quality and performance improvement activities;
- Supporting the use of patient-centered health information technologies at all stages of care to support the information and decision-making needs of the patients; and
- Ensuring the use of developmentally appropriate communication with children to build better understanding of their own health and health care.

GOAL 3: INCORPORATE ACCURATE, STANDARDS-BASED AND DEVELOPMENTALLY APPROPRIATE HEALTH AND SCIENCE INFORMATION AND CURRICULA IN CHILD CARE AND EDUCATION THROUGH THE UNIVERSITY LEVEL – Health plans and foundations can work internally and with health educators at all levels to achieve this goal by:

- Using the National Health Education Standards to develop consumer health communications (applications, benefits materials, letters, health and wellness information, etc.) and ensure they are written in plain language that is culturally and linguistically appropriate; and
- Partnering with educators to create evidence-based and engaging health education curricula.

GOAL 5: BUILD PARTNERSHIPS, DEVELOP GUIDANCE AND CHANGE POLICIES – Health plans and foundations frequently reach out to public and private entities in their communities to partner on important health issues. Productive partnerships to improve health literacy can be realized by:

- Funding initiatives that increase health literacy across sectors;
- Including health literacy in strategic plans, requests for proposals, grant awards, programs, and educational initiatives;

Figure 1. Blue Cross and Blue Shield of Minnesota and the Minnesota Health Literacy Partnership

Blue Cross and Blue Shield of Minnesota is committed to improving health literacy through its partnership and active participation in the Minnesota Health Literacy Partnership (http://www.healthliteracymn.org/), a collaboration that includes hospitals and clinics, health insurance plans, and community-based organizations. Blue Cross and Blue Shield of Minnesota was a founding partner of the Minnesota Health Literacy Partnership, and a Blue Cross and Blue Shield of Minnesota representative currently serves as chair. The Minnesota Health Literacy Partnership is an independent program of the Minnesota Literacy Council which strives to train health care providers on health literacy concepts, empower patients to ask for clear health information, and to share health literacy resources. The Partnership meets monthly to discuss ways to carry out their mission of improved health literacy in Minnesota. The Partnership's initiatives consist of courses designed to help patients of all ages feel more confident in finding health information on the internet and through their health care providers. The activities of Blue Cross and Blue Shield of Minnesota are in line with the goals of both the National Stakeholder Strategy for Achieving Health Equity and the National Action Plan for Improving Health Equity through their involvement in a partnership of community organizations and in their dissemination of culturally and linguistically appropriate materials.

- Facilitating the sharing of resources and evidence-based tools to improve health literacy; and
- Educating policymakers and other decision makers about the importance of health literacy for children and adolescents as informed healthcare consumers.

The NSS and NAPHL are national plans that can be adapted and used at the local or organizational level to provide background and guidance for health professionals and emphasize the importance of health equity and health literacy. Low levels of health literacy have been associated with adverse outcomes including more frequent visits to the emergency room and less utilization of preventive services; therefore improving health literacy is an important contributing factor to achieving health equity.[21,22] Life-long health behaviors are developed during adolescence, so it is crucial that health plans and health organizations focus efforts on improving the health literacy of this age group. Both plans underscore the value of achieving higher rates of health literacy and health equity in underserved populations, including adolescents. Figure 1 illustrates how one health plan is implementing strategies suggested in the NSS and NAPHL.

THE CURRENT STATE OF ADOLESCENT HEALTH LITERACY

In this section we highlight recent research indicating why health plans should be concerned about the sources from which adolescents currently seek health information, the credibility of information they find, and their understanding of health conditions and the health care system.

Where do adolescents access health information?

The Pew Internet & American Life Project[23] reports that the overwhelming majority of American teens, 93 percent, use the internet, compared to just 74 percent of adults. Up to 75 percent of teens who access the internet use it to look for health-related information,[24,25] most commonly about a personal problem, as opposed to the health problem of a friend or family member. Despite the fact that most parents do not feel their children should receive information about sex and sexuality through the media, a recent survey found that 60 percent of teens rely on some form of media for that information.[26] Teens also access the internet to gather information about health topics

they may find hard to discuss with others, such as drug and alcohol use, depression and sexual health.[27,28]

As mentioned previously, over 11 percent of adolescents in the U.S. are uninsured and often underutilize physician office visits.[29] This population of adolescents is at risk of relying solely on the internet and mass media for information about their health. For the 60 percent of teens who do see their primary care providers on an annual basis,[30] the internet still plays an important role in how health information is received. In fact, in a recent survey of people of all ages and internet-using behaviors, more than 48 percent of adolescents indicated that they made contact with their health care providers after first researching health information online, with more than 78 percent of them reporting feeling more comfortable with the information they received from their health care providers after having first researched the health issue online.[31] Many important health behaviors develop during adolescence; it is, therefore, crucial that adolescents are equipped with the skills to analyze and understand the information received online and through the media.

Is the information adolescents access credible?

Research indicates that adolescents are aware of the importance of accessing credible online health information; however, studies suggest that adolescents do not take steps to verify the credibility of online health information.[32] It has been widely reported that much of the health information available on the internet is not of high quality and some reports have even classified some online health information as potentially harmful.[33,34] While some health-related websites are accredited (WebMD is accredited by the largest accrediting body for health care, URAC) or sponsored by national health care organizations or government agencies, the internet remains an open-access space, and there can be no guarantee that the health information accessed by adolescents is accurate. Adolescents are at risk of not only misunderstanding the health information they receive online and through the media, but also of receiving incorrect information. Health plans and health care professionals should be aware that when adolescents visit their providers, they might have already developed incorrect or misunderstood opinions regarding diagnoses and treatment options.

How health literate are adolescents?

While there are tools available to measure adolescent health literacy, such as the Rapid Estimate of Adolescent Health Literacy in Medicine (REALM-Teen), the Institute for Medicine concluded that the current tools assess only written comprehension and do not measure other important aspects of adolescent health literacy, such as oral communication skills, critical thinking and decision-making abilities.[35,36] Therefore, knowledge of the current level of health literacy among adolescents is limited. One research study conducted focus groups to analyze health literacy skills among adolescents and found that they generally do not have a high level of health literacy and often face difficulties understanding health information that is presented to them online.[37] The National Assessment of Adult Health Literacy (NAAL) includes measurements of health literacy for people aged 16 and up. The 2003 NAAL found that 16- to 18- year-olds had a relatively low level of health literacy with people ages 25 through 39 having the highest level.[38] Another study utilized the REALM-Teen and found that adolescents have a low level of literacy when it comes to reading health-related words, spelling medical conditions, and accurately describing and writing their symptoms.[39]

Many Americans, including adolescents, do not fully comprehend their health insurance coverage and how their health is impacted by their choice of providers and treatments. In a recent survey, no adolescents reported that they searched the internet for health information because they thought accessing health care was too expensive, perhaps indicating they do not fully grasp the cost of health care and health insurance. Other research has found that in general, adolescents are unaware of their insurance coverage status.[40] Adolescents have reported that if they were aware of the fact that they had health insurance coverage, they would be more likely to make appointments with their physicians.[41] Engaging adolescents as active participants in the health care system and educating them on their health insurance status and health care options may have the beneficial effect of fostering life-

long positive health behaviors and increasing health literacy throughout their lifetimes.

OPPORTUNITIES FOR HEALTH PLANS AND FOUNDATIONS TO IMPROVE ADOLESCENT HEALTH LITERACY

Several health plans and health plan foundations have begun to recognize that where adolescents access health information and the credibility of this information are causes for concern and have created unique programs and initiatives to invest in adolescent health literacy. Here we present multiple examples of these activities, focusing on four different strategies:

1. Disseminate teen-specific newsletters and offer websites with health information for adolescents;
2. Fund projects to improve health and media literacy among adolescents;
3. Support the use of social media to improve health literacy; and
4. Educate providers about adolescent health literacy.

1. Disseminate teen-specific newsletters and offer websites with health information for adolescents

BlueCross BlueShield of Tennessee

The Volunteer State Health Plan (VSHP), a subsidiary of BlueCross BlueShield of Tennessee, serves members of TennCare, Tennessee's Medicaid managed care program, under a specific program for children and adolescents called TENNderCARE. TENNderCARE provides free check-ups, also known as well-child or well-care visits, until age 21, and covers all medically necessary care to treat problems found during the check-up, including dental, speech, hearing, vision, and behavior or mental health problems. The HEDIS rate for adolescent well-care visits increased from 2008 to 2010 among Tennessee's Medicaid managed care plans, yet it still falls below the national average, and fewer than half of adolescents enrolled in TENNderCARE are receiving this important annual visit.[42]

VSHP Volunteer State Health Plan

To encourage utilization of these visits among adolescents and promote increased understanding of important health issues, TennCare and participating Medicaid managed care plans including VSHP disseminate a quarterly newsletter targeted to teens 15 to 20 years old. The newsletters tie important health information and messages into articles on contemporary issues relevant to teens such as prom, acne, weight gain, sports, and dental health and are written at a sixth-grade reading level. VSHP recently used internal focus group feedback and market research to redesign the newsletter format to be more visually appealing to their teen audience. As an incentive for teens to schedule an adolescent well-care visit, each newsletter includes a form teens can use to

submit the date of their most recent visit to be entered into a quarterly drawing for a gift card.

In addition to the newsletters, VSHP maintains a teen-specific website "Teen Health Explosion" that hosts an archive of all of the articles disseminated in the newsletters. The website can be viewed at: http://www.teenhealthexplosion.com/. VSHP also developed a booklet, "Are You ITK?" (In the Know), that includes general health information along with information on relationships, bullying and safety; this booklet is disseminated by VSHP to each teen member.

The BlueCross BlueShield of South Carolina Foundation

The BlueCross BlueShield of South Carolina Foundation (BCBSSC Foundation) has provided over $2 million to support the South Carolina Campaign to Prevent Teen Pregnancy (SC Campaign) since 2006 for the development and implementation of pregnancy-prevention strategies for underinsured and uninsured 18 and 19 year-olds. Through this funding, the SC Campaign conducted a large research project to study teen pregnancy among 18 and 19 year-olds and found a large gap in pregnancy prevention programs for this age group despite the fact that they account for over two-thirds of all teen pregnancies in the state.[43] As a result of this report and research, the SC Campaign, in collaboration with the South Carolina Department of Health and Environmental Control (SC DHEC) and with funding from BCBSSC Foundation, developed a website dedicated to improving health literacy by providing accurate and reliable sexual and reproductive health information to teens throughout the state. In addition to general information, Carolinateenhealth.org also has a clinic locator enabling teens to find the closest clinic to access contraceptives or other health care and features a contraceptive comparison tool to educate teens about their birth control options.

During the time the website was under development, the SC DHEC and the Department of Education (DOE), with assistance from the Association of Maternal and Child Health Programs (AMCHP) and the Association of State and Territorial Health Officials (ASTHO), were exploring how to improve preconception health messaging to adolescents in the state. SC DHEC and DOE were able to partner with the SC Campaign to include preconception health information in the broader Carolinateenhealth.org website. This information about reproductive health planning includes specific tips on healthy eating, exercise and staying smoke free.

SC Campaign staff and professionals in the field of reproductive health developed the main content and ensured the medical accuracy of the site. Focus groups were conducted with youth ages 16 to 19 years old to review the content, identify topics for inclusion, and obtain feedback on how to convey messages to this age group. These youth then individually tested the website for ease of use and relevancy prior to the launch.

The content will continually be improved and expanded, and the website will be evaluated by the number of website hits, Twitter followers and Facebook friends. Additionally, clinic staff are tracking whether teens report the website as a referral source for their clinic visits. Promotional materials to advertise the website include wallet cards that are distributed at health centers, urgent care offices, colleges and youth gathering points.

The sustained investment of BCBSSC Foundation has been critical to the initial success of the website, especially since this type of interactive, teen-focused website needs to be updated on a daily basis with new information. The Foundation's interest in increasing access to and use of contraceptives among this age group was also crucial to the development of the clinic locator and contraceptive-comparison tool. The site was launched in January 2011 and had attracted nearly 6,300 unique visitors by the end of July 2011. Future plans include developing the ability to make an online appointment at a clinic and adding youth bloggers and a discussion board to make the site more interactive. Additional content for the site is also being developed on preconception health and healthy relationships, as well as expansions to the "Planning the Talk" section to encourage youth to talk

to physicians about more than just contraception and sexually transmitted infections.

Health Care Service Corporation

Recognizing the link between low levels of health literacy and poor health outcomes, Health Care Service Corporation (HCSC) created BeSmartBeWell.com®, a public health website that utilizes video storytelling to educate people about health conditions.

A study published in the Annals of Internal Medicine found that storytelling can help change a person's behavior and bad health habits.[44] As patients "enter" the world of the storytellers, they can see themselves in those situations. As noted in the study, people with high blood pressure benefited more from video storytelling than from traditional teaching methods.

Real-Life Stories for the Real World

BeSmartBeWell.com follows the model highlighted in the research, presenting real kids, real teens and real parents talking about important health issues. Topics currently covered include:

- Managing Pregnancy Risks
- Childhood Obesity
- Caregiving
- Mental Health
- Drug Safety
- Traumatic Brain Injury
- Sexually Transmitted Disease
- Domestic Violence
- Childhood Asthma
- Food Safety

Talking Health and Prevention to Teens

The BeSmartBeWell.com site recently launched a feature on "Youth in Control," which tells the stories of three teens who took control of their conditions and started making healthier choices. Their stories can be viewed at: http://www.besmartbewell.com/spotlight-newsletter/youth-in-control/index.htm.

- Tim, a high school athlete, made the transition from relying on his mom to keep track of his asthma medicine to relying on himself.
- Akeila decided enough was enough, and she was going to make some changes in her eating habits.
- Colleen learned to take control of her mental health by taking responsibility for managing her symptoms and embracing therapy.
- Other teen-focused stories include "Katie's Story," which tells the story of a young teen who thought the pills were safe because they came from the medicine cabinet. However, she got addicted, missed a lot of her childhood, and she wishes she could have it back. "Cecily's Story" is about managing a healthy pregnancy to give her baby the best shot. "Kari's Story" is the story of a happy teenager with hope and ambition; then an abusive boyfriend changed everything.

In addition to these personal-story videos, the website features leading authorities, useful links, health news and expert Q&As. In addition, Be Smart. Be Well. publishes a bimonthly email newsletter called Spotlight and a biweekly health news alert. Be Smart. Be Well. also maintains a teen-focused presence on Facebook and Twitter (@BSBW), which further extends its message of health awareness and prevention.

BeSmartBeWell.com is sponsored by Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma and Blue Cross and Blue Shield of Texas, Divisions of Health Care Service Corporation, a Mutual Legal

Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association.

2. Fund projects to improve health and media literacy among adolescents

Wellmark Foundation

The Wellmark Foundation seeks to improve the health of Iowans and South Dakotans by funding community-based wellness and prevention programs. The Foundation awarded a $25,000 grant in February 2011 to the Partnership for a Drug-Free Iowa and the Face It Together program to improve health and media literacy among middle school students in Iowa. Youth are large consumers of mass media; therefore media literacy is critical to the development of effective decision-making skills, especially as youth face choices that will have an impact on their future health, such as tobacco and alcohol use and dietary/lifestyle issues. The Partnership is using this grant to implement the Media Literacy Pilot Project in the fall of 2011 to teach youth in fifth through eighth grade in schools across the state how to interpret media messages accurately. The Pilot Project will provide a usable teaching module and is intended to be the first step in the process of designing a comprehensive curriculum plan for teaching media literacy. Activities will include:

- a 45-minute visual media presentation,
- pre- and post-presentation classroom activities,
- printed materials,
- instructor-directed teaching aids,
- survey/test modules, and
- a program web site.

The ultimate goal is for this initiative to gain acceptance and integration into the educational system following the pilot project period.

3. Support the use of social media to improve health literacy

Health Net, Inc.

Access to health insurance coverage is not the only factor affecting whether and how teens utilize the health care system. In California only 40 percent of publicly-insured teens had a well-care visit in 2010, and a higher proportion of insured teens use the emergency room than their uninsured counterparts.[45] In order to encourage appropriate use of health care and improve adolescents' level of engagement in their own health, Health Net, Inc., a Medicaid managed care plan with members in California, partnered with the UCLA School of Public Health to develop a project to improve adolescent health care literacy. The project, funded under a health literacy grant 5R01HD059756-02 from the National Institutes of Health, now also includes EPG Technologies and Weinreich Communications as partners.

Given that over 90 percent of teens use the internet and the vast majority of them (73%) use social-networking sites, the group decided to design a social-networking website — Teen2xtreme.net (T2X.me) — as the best way to reach adolescents. Development of the site was based on feedback compiled through focus groups conducted with teens throughout the state.[46] The site is organized around lifestyle issues for teens and includes social activities (e.g., status updates, blogs, polls and trivia). Teens connect to thousands of health articles from www.teenshealth.org, a website run by the Nemours Center for Children's Health Media that provides accurate, up-to-date health information reviewed by a team of pediatricians and other medical experts. Teens can also access a transmedia story via video and character interactions on the site and have a direct connection to Health Net advice nurses through an online chat feature. The goal of the site is

to improve health literacy by increasing teens' capacity to access and use their insurance, to engage actively in their health care and health behavior decisions, and to develop pro-health attitudes.

The teens initially using the site were recruited from Health Net's membership so the project will be able to correlate their health care utilization data with their usage of the site, using an intervention and control group for evaluation purposes. To increase participation and activity on the site, additional activities have been conducted including working with high school health teachers, offering incentives for participation, and reaching out directly to teens through text messages and mailings. Project partners have identified the following as keys to the successful implementation of the website:

- Include teens in the development of the site from the very beginning in an advisory committee role;
- Continually create new content to keep the teens engaged in the site;
- Utilize text messaging to drive teens to the site; and
- Take into account the financial situation and needs of the specific group of teens you are trying to reach, in this case, teens enrolled in Medicaid managed care.

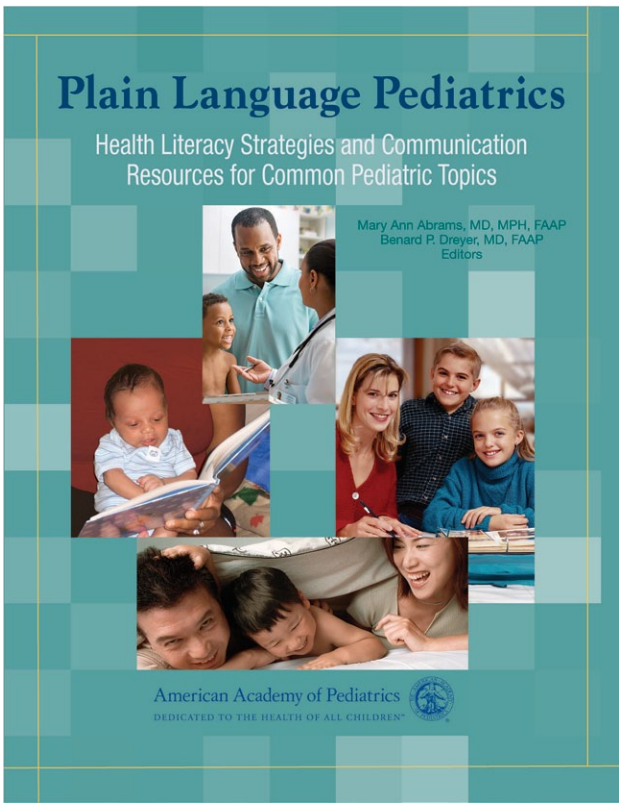
The project pilot period ends in January 2012, and at this time an additional follow-up survey will be conducted to discern how participants' knowledge, behaviors and attitudes changed with regard to health care.

5. Educate providers about adolescent health literacy

American Academy of Pediatrics

Given that nearly half of all U.S. adults have difficulty understanding and using health information, many of the parents of the children and adolescents cared for by pediatricians likely have limited health literacy.[47] In response to this problem, the American Academy of Pediatrics (AAP) created a resource to assist providers with delivering a plain language approach to communication. *Plain Language Pediatrics* combines health literacy and plain language principles to present information in a way that makes it as easy as possible for people with varying degrees of health literacy to understand and applies these principles to a variety of ambulatory acute, chronic and preventive conditions. Common pediatric topics are covered including asthma, ADHD, ear infections and medical dosing. The resource is divided into two parts, first exploring limited health literacy, including the scope of the problem, how it affects children in particular, and how health care providers can address and overcome health literacy issues with patients and their caregivers. The second part is a new series of 25 reproducible patient education handouts produced in both English and Spanish at low reading levels. These handouts contain need-to-know information, practical pronunciation guides, and simple, purposeful illustrations on specific health care topics, many relevant to adolescents including ADHD, smoking, and appropriate use of prescription and over-the-counter medications.

Health plans or providers can purchase the full volume of *Plain Language Pediatrics* and may also access the handouts online through the use of a special password inside the book. Duplication rights and access to online handouts are available to all users within the provider office or site for which the book is purchased. More information can be found at: www.aap.org/bookstore. Additional information from the AAP on health equity is available at: http://www.aap.org/commpeds/resources/health_equity.html and http://www.aap.org/research/hlp.htm.



Agency for Healthcare Research and Quality
The Agency for Healthcare Research and Quality (AHRQ) commissioned The University of North Carolina at Chapel Hill to develop and test the Health Literacy Universal Precautions Toolkit.[48] The toolkit provides step-by-step guidance and tools for providers to assess their practice and make changes in order to connect with patients of all literacy levels. The toolkit is designed for use by all levels of staff in a primary care practice and can be used with adults, adolescents and pediatric patients. The toolkit identifies four change areas that are important for promoting health literacy in a practice:

1. Improve spoken communication,
2. Improve written communication,
3. Improve self-management and empowerment, and
4. Improve supportive systems.

Tools within these four change areas that are applicable to adolescents include:

- "Teach-back" method: One of the easiest ways to close the gap of communication between clinician and patient, this method is a way to confirm that a provider has explained to the patient what they need to know in a manner that the patient understands.
- "Brown Bag Review" of medications: This is a common practice that encourages patients to bring all of their medications and supplements to medical appointments and provides clinical staff with an opportunity to review and discuss the medications that the patient is taking.
- "Ask Me 3": This program, designed by the National Patient Safety Foundation, encourages patients to know three things before leaving the encounter: 1) What is my main problem? 2) What do I need to do? and 3) Why is it important for me to do this? Downloadable brochures and materials on the program are available at: http://www.npsf.org/askme3/

The Health Literacy Universal Precautions Toolkit includes additional details on these and other tools to improve health literacy, along with additional resources such as forms, PowerPoint presentations, worksheets and posters that support the implementation of the tools. The toolkit is available at: http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf.

CONCLUSION

Eliminating disparities and achieving health equity for all Americans will be achieved only through collaboration among the various sectors that impact the determinants of health throughout a person's lifetime. While it remains a daunting task, arming adolescents with skills and tools to understand health care and ultimately empower them to make healthy decisions provides a great opportunity to set them on a path to healthier lives. As illustrated in this brief, it is imperative for health plans and health plan foundations to invest in adolescent health literacy and to promulgate successful efforts from their peers in the hope of improving adolescent health literacy and achieving health equity for our nation's adolescents.

ENDNOTES

1 *Fact Sheet on Demographics: Adolescents*. National Adolescent Health Information Center, University of California, San Francisco. 2003.

2 Ibid.

3 *Healthy People 2020*. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2011.

4 *Adolescent Identity Development*. ACT 4 Youth Center for Excellence. Available at: http://www.actforyouth.net/health_sexuality/adolescence/identity/; accessed 6/11/2011.

5 Lawrence RS, Gootman JA, Sim LJ, editors. *Adolescent health services: Missing Opportunities*. National Research Council and Institute of Medicine, Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development. Washington: National Academies Press, 2009. Available from: http://books.nap.edu/openbook.php?record_id=12063&tpage=1

6 *Healthy People 2020*, 2011.

7 Jenkins R. Presentation during National Institute for Health Care Management (NIHCM) Foundation webinar on May 25, 2011, "Health Disparities Through an Adolescent Lens."

8 Ibid.

9 *Table HI08. Health Insurance Coverage Status and Type of coverage by Selected Characteristics for Children Under 18: 2009*. U.S. Census Bureau. Available at: http://www.census.gov/hhes/www/cpstables/032010/health/h08_000.htm; accessed 6/11/2011.

10 Brooks T. Presentation during National Institute for Health Care Management (NIHCM) Foundation webinar on August 17, 2010, "What Does the Affordable Care Act Do for Adolescents & Young Adults?"

11 Bisgaier J, Rhodes KV. Auditing Access to Specialty Care for Children with Public Insurance. *New England Journal of Medicine*, 2011;364:2324-2333.

12 Lawrence RS, Gootman JA, Sim LJ, editors. 2009.

13 Sommers BD, Rosenbaum S. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. *Health Affairs, 2011*;30(2):228-236.

14 *National Action Plan to Improve Health Literacy*. U.S. Department of Health and Human Services, Office of Disease Prevention and Promotion, 2010. Available at http://www.health.gov/communication/HLActionPlan/

15 Ibid.

16 Ibid.

17 Rollins, R. Presentation during National Institute for Health Care Management (NIHCM) Foundation webinar on May 25, 2011, "Health Disparities Through an Adolescent Lens."

18 *National Stakeholder Strategy for Achieving Health Equity*. U.S. Department of Health and Human Services, Office of Minority Health, 2010. Available at http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

19 *National Action Plan to Improve Health Literacy*. U.S. Department of Health and Human Services, Office of Disease Prevention and Promotion, 2010. Available at http://www.health.gov/communication/HLActionPlan/

20 Barrett, SE, Puryear JS, Westpheling K. *Health Literacy Practices in Primary Care Settings: Examples From the Field*. The Commonwealth Fund, January 2008.

21 Berkman ND, DeWalt DA, Pignone MP, et al. *Literacy and Health Outcomes. Evidence Report/Technology Assessment No. 87*. Agency for Healthcare Research and Quality, 2004.

22 Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low Health Literacy and Health Outcomes: An Updated Systematic Review. *Annals of Internal Medicine*, 2011;155(2):97-107.

23 Lenhart A, Purcell K, Smith A, Zickuhr K. *Social Media & Mobile Internet Use Among Teens and Young Adults*. Pew Internet & American Life Project, Pew Research Center, February 3, 2010. Accessed at http://pewinternet.org/Reports/2010/Social-Media-and-Young-Adults.aspx on April 14, 2011.

24 Ybarra M, Suman M. Reasons, assessments, and actions taken: sex and age differences in uses of Internet health information. *Health Education Research*, 2008;23(3):512-521.

25 Rideout V. Generation Rx.com How Young People Use the Internet for Health Information. *Kaiser Family Foundation Survey*, December 2001.

26 Lagus KA, Bernat DH, Bearinger LH, Resnick MD, Eisenberg ME. Parental Perspectives on Sources of Sex Information for Young People. *Journal of Adolescent Health*, 2011;49:87-89.

27 Lenhart et al. 2010.

28 Rideout 2001.

29 Ziv A, Boulet JR, Slap GB. Utilization of Physician Offices by Adolescents in the United States. *Pediatrics*, 1999;104(1):32-42.

30 MacKay AP, Duran C. *Adolescent Health in the United States, 2007*. National Center for Health Statistics, 2007.

31 Ybarra et al. 2008.

32 Hesse BW, Nelson DE, Kreps GL, Croyle RT, Arora NK, Rimer BK. Trust and Sources of Health Information: The Impact of the Internet and Its Implications for Health Care Providers: Findings from the First Health Information National Trends Survey. *Archives of Internal Medicine*, 2005;165:2681-24.

33 Eysenbach G, Powell J, Kuss O, et al. Empirical studies assessing the quality of health information for consumers on the world wide web. *Journal of the American Medical Association*, 2002;287:2691-700.

34 Ybarra et al. 2008.

35 Nielsen-Bohlman L, Panzer AM, Kindig DA. *Health Literacy: A Prescription to End Confusion*. Institute of Medicine, 2004.

36 Manganello JA. Health literacy and adolescents: a framework and agenda for future research. *Health Education Research*, 2008;23(5):840-847.

37 Gray NJ, Klein JD, Noyce PR, Sesselberg MA, Cantrill JA. The Internet: A window on adolescent health literacy. *Journal of Adolescent Health*, 2005;37(3):243.

38 *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy*. U. S. Department of Education.

39 Davis TC, Wolf MS, Arnold CL, et al. Development and validation of the rapid estimate of adolescent literacy in medicine (REALM-Teen): a tool to screen adolescents for below-grade reading in health care settings. *Pediatrics*, 2006;118:e1707-14.

40 Ryan SA, Millstein SG, Kang M, Ensminger ME, Starfiled B, Irwin Jr. CE. Adolescents' Knowledge of Their Health Insurance Coverage. *Journal of Adolescent Health*, 1998;22(4):293-299.

41 National Coalition on Adolescent Health Annual Meeting June 29, 2011. Comments from Youth Panel

42 *2010 HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations*. Final Report, August 2010. State of Tennessee, Department of Finance and Administration,

Bureau of TennCare. Available at http://www.tn.gov/tenncare/forms/hedis10.pdf; accessed 6/17/11.

43 Kershner S, Flynn S. *The Population Left Behind:2009*. South Carolina Campaign to Prevent Teen Pregnancy, 2009.

44 Houston TK, Allison JJ, Sussman M, Horn W, Holt CL, Trobaugh J, et al. Culturally appropriate storytelling to improve blood pressure. A randomized trial. *Annals of Internal Medicine*, 2011;154:77-84.

45 Weinreich, N. Presentation during NIHCM Foundation webinar May 25, 2011, "Using Social Media to Improve Adolescents' Health Literacy." Available at http://www.nihcm.org/images/stories/Weinreich_Presentation_052511.pdf; accessed 6/17/2011.

46 Ibid.

47 Abrams MA, Dreyer B. *Plain Language Pediatrics: Health Literacy Strategies and Communication Resources for Common Pediatric Topics*. American Academy of Pediatrics, 2009. Available at: https://www.nfaap.org/netFORUM/eweb/DynamicPage.aspx?webcode=aapbks_productdetail&key=7c5e160d-fa79-468f-8503-20a524bc5ae9#.

48 DeWalt DA, Callahan LF, Hawk VH, Broucksou KA, Hink A, Rudd R, Brach C. *Health Literacy Universal Precautions Toolkit*. AHRQ Publication No. 10-0046-EF. Agency for Healthcare Research and Quality, April 2010.

About NIHCM Foundation

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About This Brief

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INFORMATIONAL LETTER NO.1062

DATE: October 13, 2011

TO: All Iowa Medicaid Providers Billing Electronically

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Important 5010 HIPAA Transition Information

EFFECTIVE: January 1, 2012

The Version 5010 transition is less than three months away for all HIPAA covered entities. This means that to submit transactions electronically, all covered entities must upgrade from Version 4010/4010A to Version 5010. Version 5010, unlike version 4010, accommodates the new ICD-10 code sets and is a required preliminary step for the use of the new ICD-10 medical code sets.

To ensure there is no disruption of claim submissions on January 1, 2012, the Iowa Medicaid Electronic Data Interchange Support Services (EDISS) encourages all trading partners to enroll in Total OnBoarding (TOB) well before the January 2012 deadline. If the TOB profile has not been enrolled for 5010 as of this date, the provider will no longer be active for electronic transactions because the current (4010) setup will be deleted from the EDISS system. Effective October 1, 2011, new enrollees will only be allowed to register for the 5010 format for any new transactions (no more new 4010), which is consistent with Medicare.

A common question that EDISS receives is, “What exactly should I be doing for the 5010 transition?” To assist with the 5010 transition, follow the guidelines on the checklist on the EDISS website at http://www.edissweb.com/docs/shared/5010_checklist.pdf. The checklist is separated into three sections: Direct Providers (not using PC-ACE Pro32), Direct Providers (using PC-ACE Pro32), and Providers sending files through a Clearinghouse or Billing Service. Select the most appropriate section and follow the guidelines on the checklist to begin preparing for the transition.

As part of this transition, any additional electronic transaction user’s access in 4010 (i.e., 835, 270/271, 276/277) will need to be re-registered for the 5010 format through TOB. Re-registering will ensure electronic functionality is not removed at the time of 5010 cut over.

A substantial change that is occurring with HIPAA 5010 Implementation is the replacement of the Noridian Claim Confirmation Report (CCR). The CCR is also known as the Gen Report. Across all lines of business for 5010, the CCR will be replaced by the 277CA.

277CAs will be returned to the Trading Partner 5010 mailboxes, the same way that CCRs were in 4010. However, 277CAs will be delivered in ANSI X12 format. Trading Partners will

need to either view the 277CAs in text format, or they can use their billing software to translate the 277CA into a readable document similar to the CCR.

EDISS recommends that all trading partners check with their in-house billing software, external software vendor, billing service, or clearinghouse to ensure the 277CA will be able to be translated. If your vendor cannot translate the 277CA, PC-ACE Pro32 has that functionality and could be used by your facility.

Please visit www.cms.gov/ICD10 for the latest news and resources to help you prepare for the transition to both 5010 as well as ICD-10.

If you have any questions, please contact the IME Provider Services Unit, 1-800-338-7909, locally 515-256-4609 or by email at imeproviderservices@dhs.state.ia.us.

Maternal Health, Child Health and Family Planning (MCHFP) FFY2011 Year End Report Instructions

- You can retrieve your Year End Report (YER) template forms from your agency's *Report Templates* file folder on SharePoint.
- Download the forms and complete them.
- After completion, compress the form(s)/file(s) and upload into your agency's *Completed Reports* file folder on SharePoint.

Maternal Health Year End Report Instructions

Part 1: MH Activities

- In the "year-end reporting" column, for each activity indicate "yes" if the activity was completed or "no" if the activity was not completed.
- If an activity was not completed, ***include a brief explanation***.

Part 2: Data

- Maternal Health Data – Report the following for FFY 2011 using the method or data set described on the form.
    - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
    - Percent of women who report a medial home
    - Date (MM/DD/YY) that WHIS data entry was completed
    - Unduplicated number of MH clients served

Part 3: MH Successes and Challenges

- Provide a brief narrative about your greatest ***success*** related to progress in any of your MH performance measures.
- Provide a brief narrative about your greatest ***challenge*** related to progress in any of your MH performance measures.
- Provide a ***client-specific story*** that demonstrates a success or challenge related to your MH program. This would relate to a specific MH client served. The name or any other identifiers need not be included in your story.

Child Health Year End Report Instructions

Part 1: CH Activities

- In the "year-end reporting" column, for each activity indicate "yes" if the activity was completed or "no" if the activity was not completed.
- If an activity was not completed, ***include a brief explanation***.

Part 2: Data

- Child Health Data – Report the following for FFY 2011 using the method or data set described on the form.
    - Percent of inform completions (CAReS data)
    - Percent of Medicaid enrolled children ages 0-21 who received at least one preventive health screen
    - Percent of children served who report a medical home
    - Percent of children fully immunized by the age of 24 months
    - Percent of children ages 9-35 months receiving a blood lead test
    - Number of child care businesses receiving on-site CCNC services
    - Date (MM/DD/YY) that CAReS data entry was completed
    - Unduplicated number of CH clients served

- Early Access Data – Report the following for FFY 2011 using the method described on the form.
    - Number of trained service coordinators for your service area
    - Names of the service coordinators that served children
    - Number of Early ACCESS referrals received
    - Number of children that received service coordination from your agency
    - Percent of children referred to the child health agency who received Early ACCESS service coordination from the child health agency
    - Number of referrals that were transferred to the Area Education Agency (AEA) after the initial IFSP was written
    - Number of referrals received for elevated blood lead levels for children who were already receiving services through the AEA
    - Number of referrals received for children over the age of 3 years
    - Number of referrals for families who were unreachable or had moved out of state

Part 3: CH Successes and Challenges

- Provide a brief narrative about your greatest ***success*** related to progress in any of your CH performance measures.
- Provide a brief narrative about your greatest ***challenge*** related to progress in any of your CH performance measures.
- Provide a ***client-specific story*** that demonstrates a success or challenge related to your CH program. This would relate to a specific client/family served. The name or any other identifiers need not be included in your story.

CH-Oral Health Year End Report Instructions

Part 1: CH-OH Activities

- In the "year-end reporting" column, for each activity indicate "yes" if the activity was completed or "no" if the activity was not completed.
- If an activity was not completed, ***include a brief explanation.***

Part 2: CH-OH Performance Measures

- For each performance measure, provide the current measure (FFY2010) in the appropriate column for each county within the service area. (Data available at http://www.idph.state.ia.us/hpcdp/oral_health_reports.asp)

Part 3: CH-OH Successes and Challenges

- Provide a brief narrative about your greatest ***success*** related to progress in your I-Smile™ program.
- Provide a brief narrative about your greatest ***challenge*** related to progress in your I-Smile™ program.
- Provide a ***client-specific story*** that demonstrates a success or challenge related to your I-Smile™ program.

Family Planning Year End Report Instructions

Part 1: FP Activities

- In the "year-end reporting" column, for each activity indicate "yes" if the activity was completed or "no" if the activity was not completed.
- If an activity was not completed, ***include a brief explanation***.

Part 2: FP Successes and Challenges

- Provide a brief narrative about your greatest ***success*** related to progress in any of your FP performance measures.
- Provide a brief narrative about your greatest ***challenge*** related to progress in any of your FP performance measures.
- Provide a ***client-specific story*** that demonstrates a success or challenge related to your FP program. This would relate to a specific FP client. The name or any other identifiers need not be included in your story.

Instructions for Compressing and Un-compressing File(s) or Folder(s)

Compressing File(s) or Folder(s) Using XP and Windows 7

1. Right click **file** or **folder**
2. Arrow down to **Send To**
3. Left click **Compressed (zipped) Folder** (this creates a zipped folder of the file or folder)

OR

1. In folder where file is located click **file**
2. Click **new**
3. Click **PKZip file**
4. Click third icon – **Add files**
5. Highlight **file** or **folder**
6. Click **Add files**
7. Click **done**
8. Click **OK**

Un-compress File or Folder using XP

1. Right click **file** or **folder**
2. Left click **Extract All**
3. Click **Next**
4. Click **Browse** to specify where you want to extract the file or folder
5. Click **Next** to extract to selected location
6. Click **Finish**

Un-compress File or Folder using Windows 7

1. Right click **file** or **folder**
2. Left click **Extract All**
3. Click **Browse** to specify where you want to extract the file or folder
4. Click **Extract**

OH Consultant Assignments for MCH Contractors
FFY2012

AGENCY	CH	MH	OH LEAD
Allen Memorial Hospital Women's Health of Waterloo		X	Heather Miller
American Home Finding Association	X	X	Tracy Rodgers
Black Hawk County Health Department	X	X	Heather Miller
Crawford County Home Health, Hospice & Public Health	X	X	Mary Kay Brinkman
FAMILY, Inc.	X	X	Tracy Rodgers
Hawkeye Area Community Action Program	X	X	Heather Miller
Hillcrest Family Services		X	Heather Miller
Johnson County Public Health	X	X	Heather Miller
Lee County Health Department	X	X	Tracy Rodgers
Marion County Public Health	X	X	Mary Kay Brinkman
MATURA Action Corporation North – O'Brien, Osceola, BV, Clay Dickinson South – Adair, Adams, Union Ringgold, Decatur	X	X	Mary Kay Brinkman
Mid-Iowa Community Action, Inc.	X	X	Heather Miller
Mid-Sioux Opportunity, Inc.	X	X	Mary Kay Brinkman
New Opportunities, Inc.	X	X	Mary Kay Brinkman
North Iowa Community Action Organization	X	X	Mary Kay Brinkman
Scott County Health Department	X		Heather Miller
Siouxland Community Health Center	X		Mary Kay Brinkman
Siouxland District Health Department		X	Mary Kay Brinkman
Taylor County Public Health	X	X	Mary Kay Brinkman
Trinity Health System	X	X	Heather Miller
Visiting Nurse Association of Dubuque	X		Heather Miller
Visiting Nurse Services of Iowa West – Polk, Jasper , Poweshiek, Mahaska East – Jackson Clinton, Scott (MH)	X	X	Heather Miller
Warren County Health Services	X	X	Mary Kay Brinkman
Washington County Public Health	X	X	Heather Miller
Webster County Public Health	X	X	Mary Kay Brinkman

Updates from the Bureau of Oral and Health Delivery Systems

Bureau of Oral and Health Delivery Systems
Reminder: Your oral health consultants and Dr. Russell are part of the Bureau of Oral and Health Delivery Systems. The main phone number for the bureau is now 515-242-6383. However, all staff phone numbers are the same, as well as our toll-free number (1-866-528-4020). And don't forget to use the new email addresses for all IDPH staff! (firstname.lastname@idph.iowa.gov)

Community Water Fluoridation
Please remain alert regarding any changes in water fluoridation within the communities you serve. IDPH is aware of several towns that are eliminating water fluoridation, leaving the natural levels too low for adequate decay prevention. IDPH is part of a public-private partnership with other state stakeholders that will develop consistent messaging and a more organized front so that we may ensure Iowans receive the full benefit of this cost-effective public health preventive measure.

New place. New look. Healthier smiles.
The I-Smile™ Dental Home Initiative website is at www.ismiledentalhome.iowa.gov. We've changed the site location and updated the look. It's a great place for providers and families to learn more about I-Smile™ and children's oral health!

School screening
The 2010-2011 school dental screening audit report is final and available on the IDPH website at: http://www.idph.state.ia.us/hpcdp/oral_health_school_screening.asp. Student compliance improved to 67 percent, an increase from the 2009-2010 rate of 60 percent! OHC will continue to pursue ways to impact having more students submit valid certificates. Future efforts will also focus on ensuring that a useable audit form is submitted for all schools; in 2010-2011, the school compliance rate was 88 percent.

Oral Health Consultant Changes
For FFY2012, there are a few changes to MCH agency oral health consultant assignments. Sara Schlievert will no longer serve as a consultant to agencies due to recent staff changes, budget reductions, and bureau program integration. The new agency/oral health consultant list is included in your meeting packets.

Federally Qualified Health Centers
I-Smile™ and CH-Dental funds may NOT be used for direct dental services provided within FQHC dental clinics. This does not mean that you should not continue to partner with FQHCs to keep the families you serve healthy – FQHCs are a great place for families to receive all health services and an excellent place to refer your Medicaid-enrolled clients! If you have questions, please contact your oral health consultant**.**

I-Smile™ Needs Assessment
Each CH contractor is required to complete an I-Smile™ Needs Assessment this year. The template will be shared with the I-Smile™ Coordinators at their meeting on Friday. The final documents are due February 1, to be uploaded to SharePoint.

Dental Public Health Training (I-Smile™ Coordinators)
I-Smile™ Coordinators will be required to complete a six-part dental public health training, developed by IDPH in collaboration with Des Moines University. The purpose of the training is to ensure that all coordinators have a standardized public health background. At Friday's I-Smile™ Coordinator meeting, each coordinator will receive the training packet. Coordinators must view the training modules and complete the post-tests by April 1, 2012. Dental CEUs will be awarded.

Meals at Meetings
We will no longer be able to provide lunch at the I-Smile™ Coordinator meetings, in adherence with new IDPH policy. Delta Dental of Iowa graciously agreed to provide assistance for this week's meeting. However, for future meetings we will ask that each coordinator bring a check from their CH agency to cover the cost of the meal.

Dental Data Reports, FFY2012
The dental data report is used to track CH-dental funding used to reimburse dentists for eligible CH clients. Minor changes have been made to the quarterly reporting form (PDF) for FFY2012. In addition to adding instructions to the report, it has been formatted to allow all 4 quarters to be used on the same form. When completing it, do not delete the information from earlier quarters. Also, there is no longer a need to include a description of your agency's use of CH-dental funds for infrastructure-building activities on this report.

I-Smile™ Electronic Expenditure Workbook
The EEW for I-Smile™ will have a slightly different look for FFY2012, in an effort to reduce confusion about the direct service cost reporting. Please see the attached example, which includes an explanation at the bottom of the page. If you or your fiscal staff has questions, please contact your oral health consultant or Amy Janssen. *See sample on the next page.*

I-Smile OCTOBER - JUNE

	GRANT FUNDS					PROGRAM INCOME						
Budget Category	**BUDGETED**	**MONTHLY TOTAL**	**Grant Funds YTD**	**% of Total YTD**	***FFY 2011 Operating Capital Funds Retained***	**Title XIX**	**Third Party Payors**	**Empowerment**	**In-Kind**	**Other Funds**	**Program Income Monthly Total**	**Program Income YTD**
A. Salaries/Fringe	**0.00**	☼	0.00	#DIV/0!							0.00	0.00
B. Contracted Providers	**0.00**	☼	0.00	#DIV/0!							0.00	0.00
C. Equipment	**0.00**	☼	0.00	#DIV/0!							0.00	0.00
D. Other	**0.00**	☼	0.00	#DIV/0!							0.00	0.00
E. Indirect/Admin	**0.00**	☼	0.00	#DIV/0!							0.00	0.00
TOTAL	**0.00**	**0.00**	0.00	#DIV/0!		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Monthly Collections											0.00	0.00
Program Income Balance						0.00	0.00	0.00	0.00	0.00	0.00	0.00
Direct Service Reporting	**0.00**	!!	0.00									

The section designated in yellow, to the left, is required for reporting purposes. This is where you enter the total expenses for the month for direct services provided to non medicaid enrolled children. This shall not exceed your approved budgeted amount for direct services. ***NOTE: The total inserted in this yellow section is not tied in by formulas to the Monthly total amount above.***

☼ **Insert MONTHLY TOTAL to be billed to I-Smile™ by line item category. Note: Include your allowable direct service costs in these line item totals (see RFP, RFA, and contract for guidance on allowable direct service costs).**

!! **THEN, specifically identify the TOTAL direct service costs that were included in the MONTHLY TOTAL column within the *Direct Service Reporting* row at the bottom of the worksheet (this row is yellow on the actual EEW).**

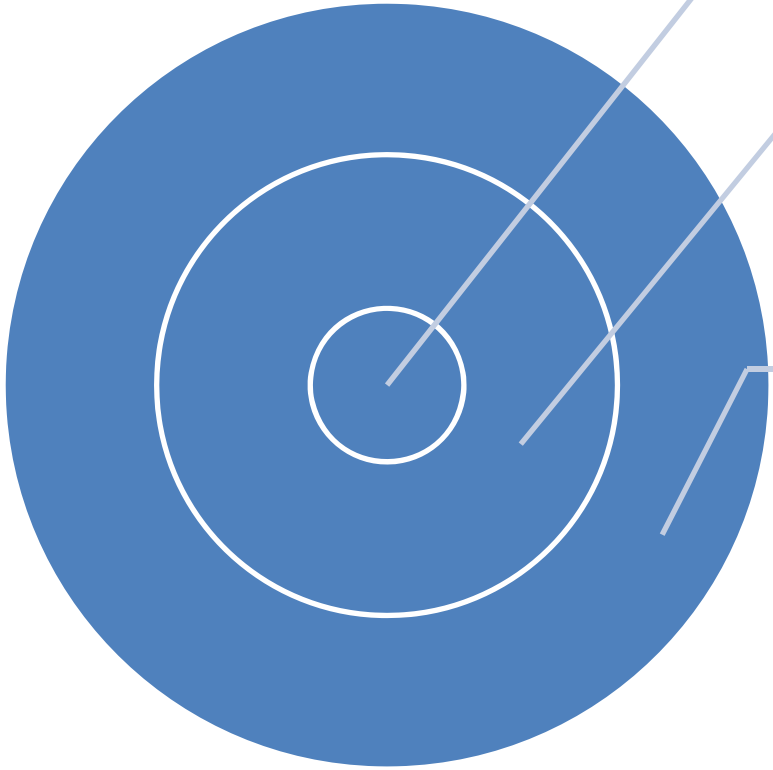
Iowa's Health Needs: Maternal and Child Health

2010-2011

CHNA & HIP

Iowa Department of Public Health

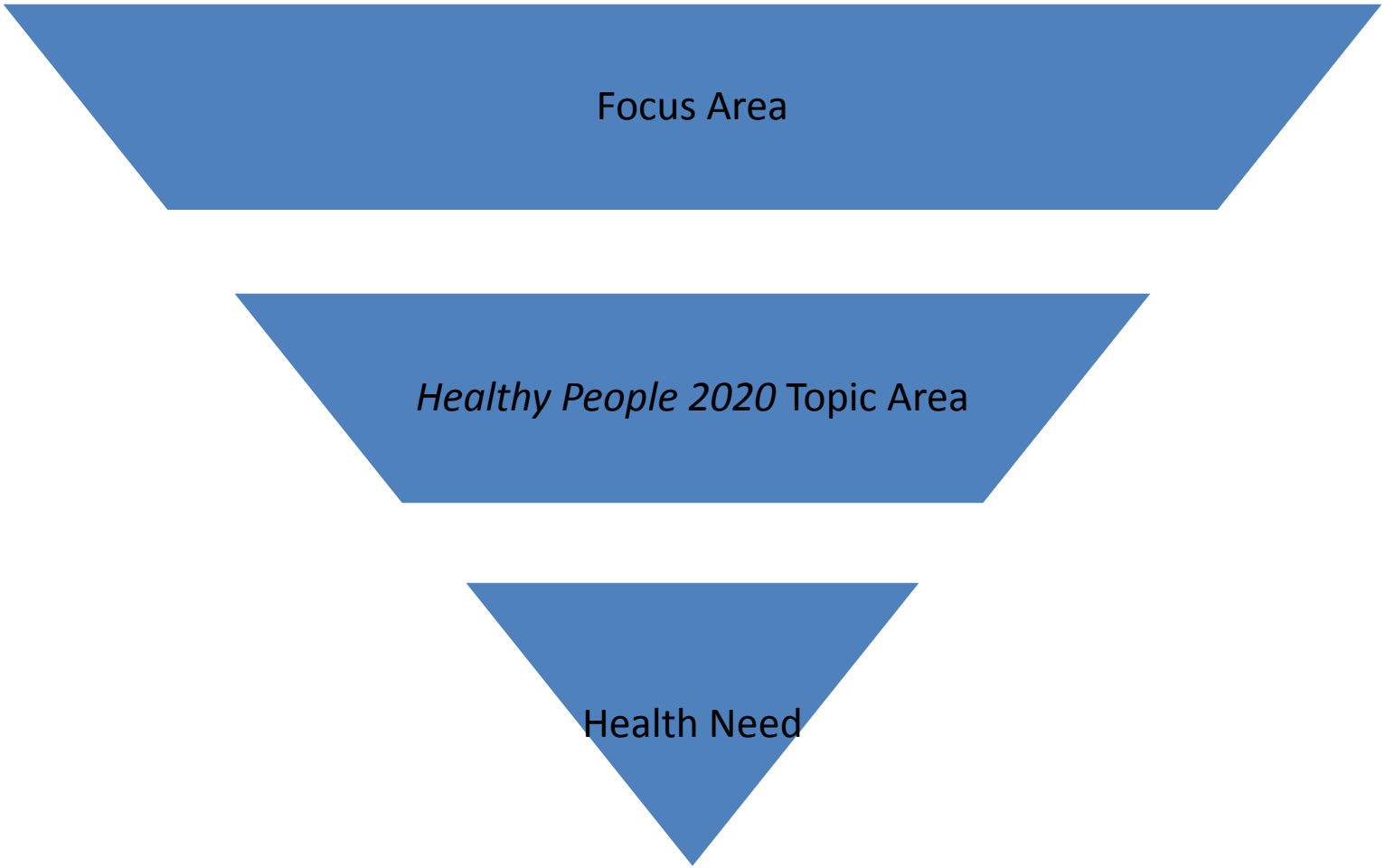
Methodology



CHNA & HIP

Iowa Department of Public Health

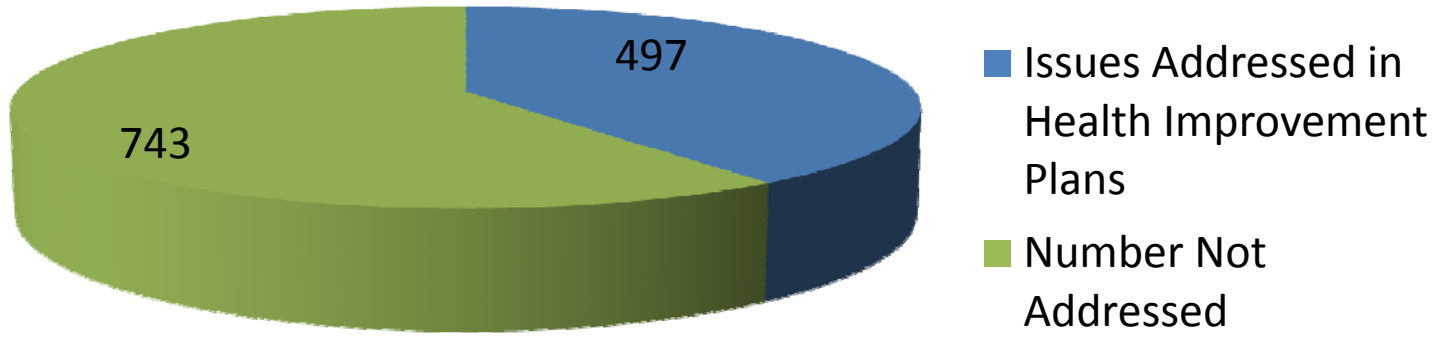
Methodology



CHNA & HIP
Iowa Department of Public Health

General Findings

Breakdown of CHNA vs. HIP



CHNA & HIP

Iowa Department of Public Health

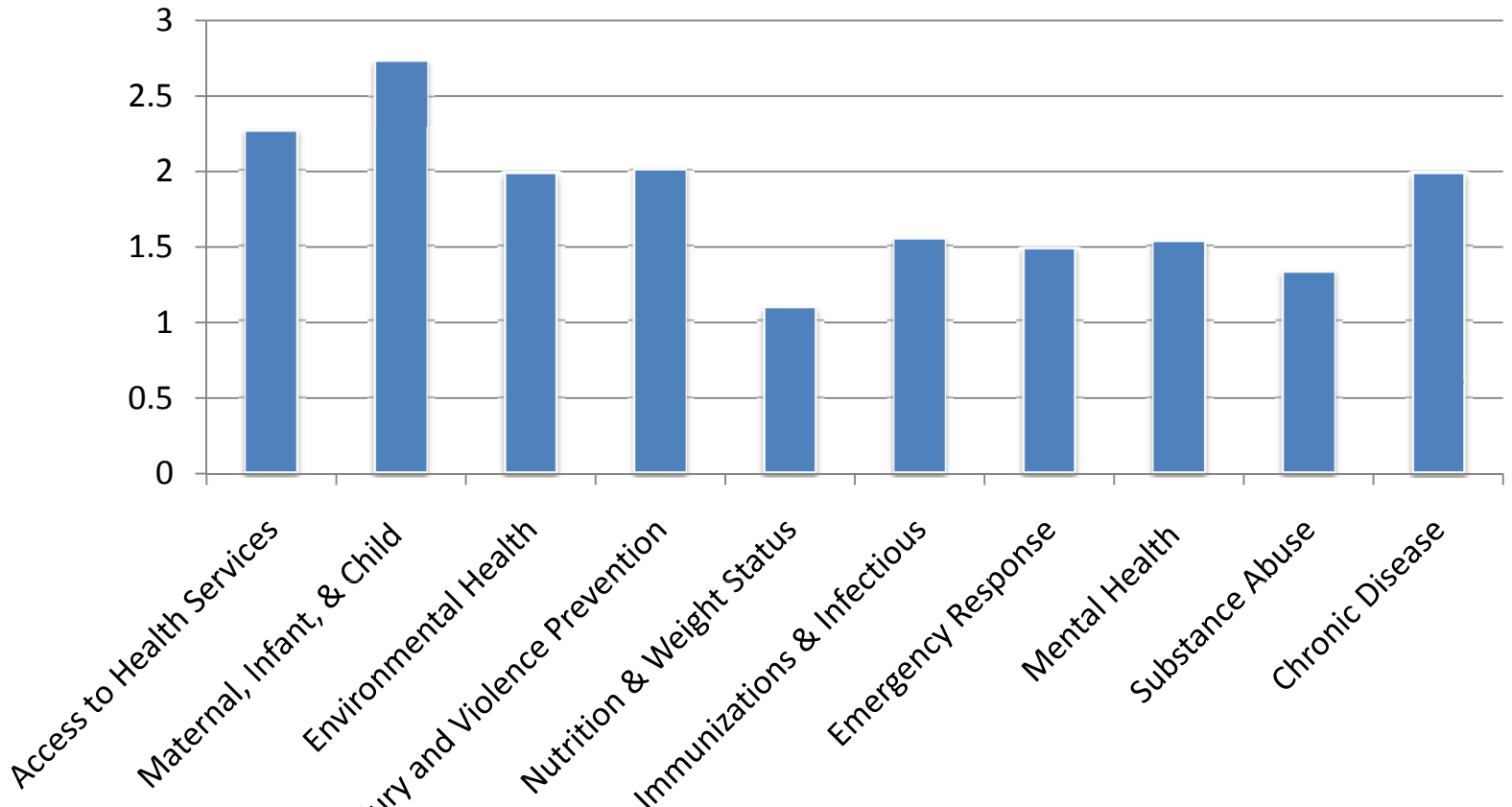
Ten Most Frequently Cited Broad Category/Healthy People 2020 Topic Area

Broad Category/Healthy People Topic Area Identified	Number of Counties	IDPH Focus Area
Access to Health Services	92	Health Infrastructure
Maternal, Infant, and Child Health	87	Healthy Behaviors
Environmental Health	83	Environmental Health
Injury and Violence Prevention	79	Prevent Injuries
Nutrition and Weight Status	77	Healthy Behaviors
Immunizations and Infectious Disease	72	Prevent Epidemics
Preparedness	66	Emergency Response
Mental Health and Mental Disorders	61	Healthy Behaviors
Substance Abuse	58	Healthy Behaviors
Chronic Disease	48	Healthy Behaviors

CHNA & HIP

Iowa Department of Public Health

Average # of Issues Identified per Top 10 Broad Category/ HP 2020 Topic



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Iowa Department of Public Health

Detailed Needs by Broad Category/HP 2020 Topic

	Needs	Number of Counties	Percentage of Counties
Maternal, Infant, and Child Health		87	41.4%
	Family Planning	29	29.3%
	Prenatal Care	14	14.1%
	Lack of Providers/Services	10	10.1%
	Breastfeeding	6	6.1%
	Parental Education-Child Wellness	6	6.1%

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Iowa Department of Public Health

Detailed Needs by Number of Counties Identifying Need

Obesity and Overweight	Healthy Behaviors	74	74.7%
Access to Transportation	Health Infrastructure	41	41.4%
Water Quality	Environmental Health	41	41.4%
Motor Vehicle Accident Prevention	Prevent Injuries	36	36.4%
Access to Mental Health Services	Health Infrastructure	35	35.4%
Cancer	Healthy Behaviors	35	35.4%
Youth Substance Abuse	Healthy Behaviors	32	32.3%
Educational and Community Based Programs	Health Infrastructure	32	32.3%

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Iowa Department of Public Health

Detailed Needs by Number of Counties Identifying Need

Lead Poisoning and Screening	Environmental Health	32	32.3%
HIV/STD Prevention, Screening, and Treatment	Prevent Epidemics	31	31.3%
Emergency Response: Communication and Network	Emergency Response	30	30.3%
Family Planning	Healthy Behaviors	29	29.3%
Heart Disease and Stroke	Healthy Behaviors	28	28.3%
Social Determinants of Health	Health Infrastructure	27	27.3%
Tobacco	Healthy Behaviors	27	27.3%

CHNA & HIP

Iowa Department of Public Health

Detailed Needs by Number of Counties Identifying Need

General Mental Health	Healthy Behaviors	25	25.3%
Access to Health Insurance	Health Infrastructure	23	23.2%
Childhood Immunizations	Prevent Epidemics	23	23.2%
Child Abuse Prevention and Child Safety	Prevent Injuries	23	23.2%
Emergency Response: Volunteers and Personnel	Emergency Response	23	23.2%
Suicide Prevention	Injury Prevention	22	22.2%
Economic Barriers to Health Services	Health Infrastructure	21	21.2%

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Iowa Department of Public Health

Unmet Needs by Broad Category/HP 2020 Topic

Broad Category	Number of Counties identifying Need	Number of Counties Including Need in HIP	Unmet Need as a Percentage of Counties Identifying	Statewide Unmet Need
Access to Health Services	92	43	53.3%	49.5%
Maternal, Infant, and Child Health	87	63	27.6%	24.2%
Environmental Health	83	31	62.7%	52.5%
Injury and Violence Prevention	79	32	59.5%	47.5%
Nutrition and Weight Status	77	63	18.2%	14.1%
Immunizations and Infectious Disease	72	26	63.9%	46.5%
Emergency Response	66	25	62.1%	41.4%
Mental Health	61	30	50.8%	31.3%
Substance Abuse	58	39	32.8%	19.2%
Chronic Disease	48	22	54.2%	26.3%

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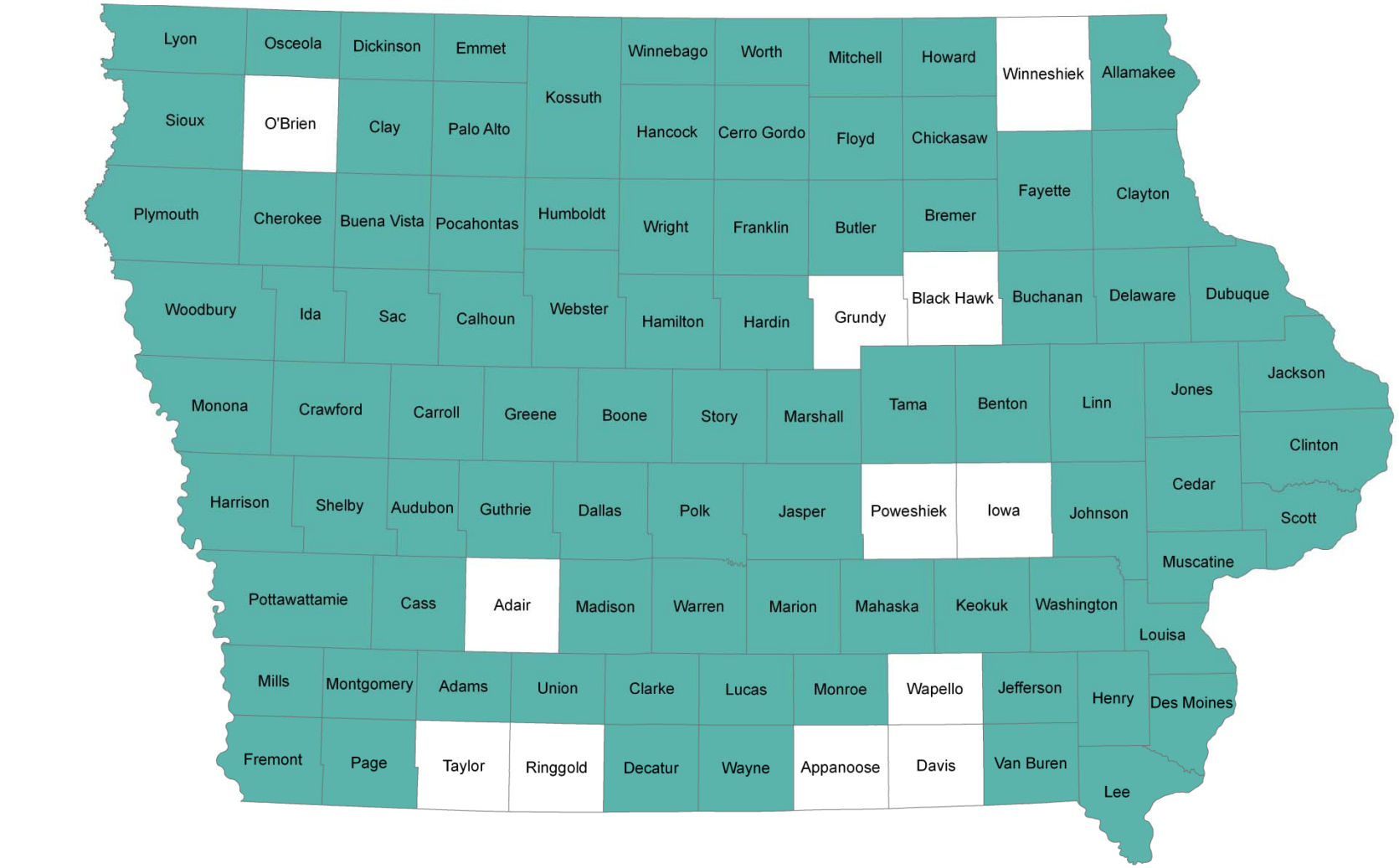
Iowa Department of Public Health

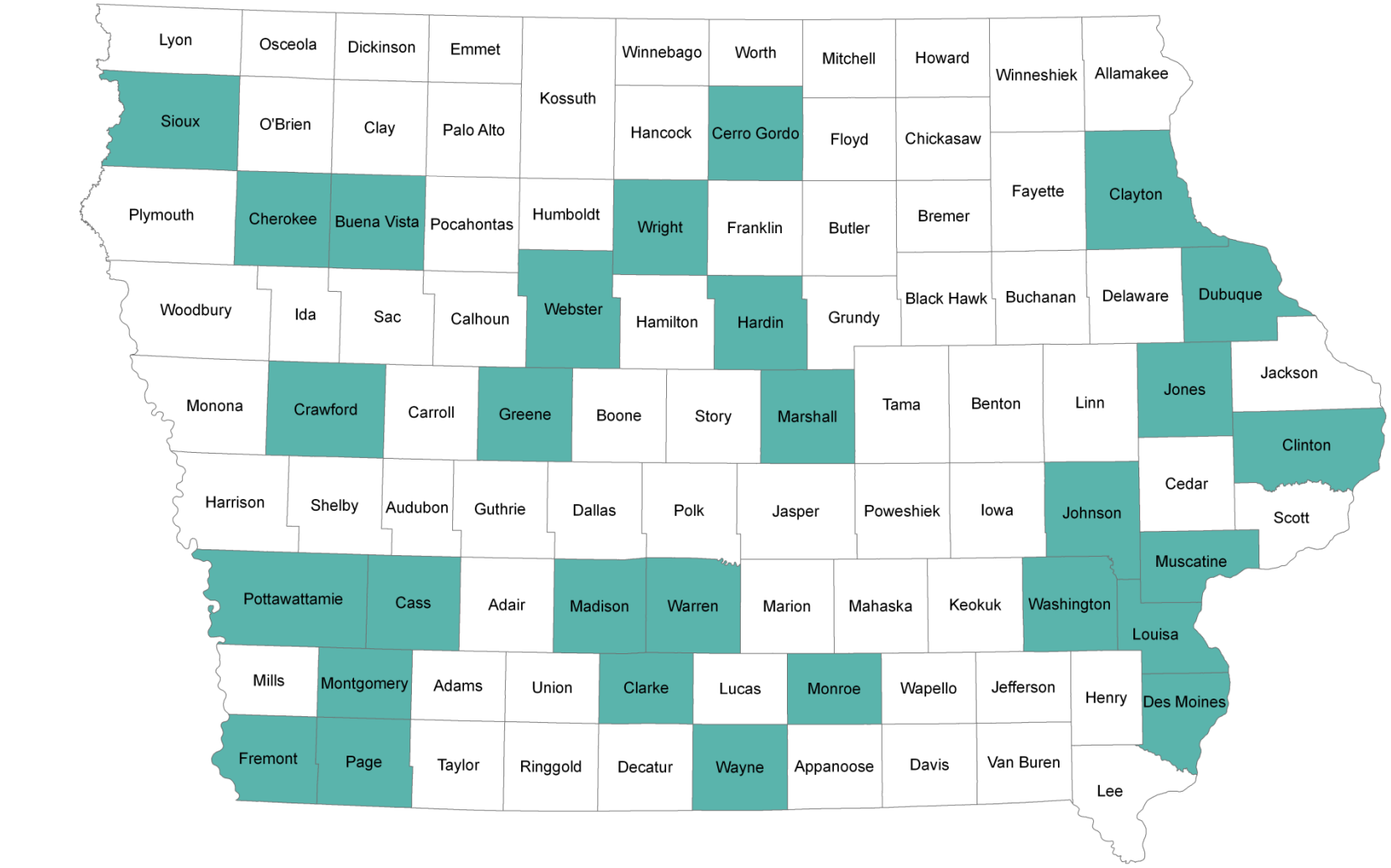
Maternal and Child Health Issues



Not Identified

Need Identified

Maternal and Child Health: Family Planning Issues



Not Identified

Need Identified

What Next?

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Iowa Department of Public Health

- State Health Assessment: *State of the State's Health*
- State Health Improvement Plan: *Healthy Iowans*
- Department Strategic Planning
- Better data collection and understanding of impacts of programs

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Iowa Department of Public Health

Healthy Iowans Topic Areas

- Access to Quality Health Services
- Acute Disease
- Addictive Behaviors
- Chronic Disease
- Environmental Health
- Healthy Living
- Injury and Violence
- Mental Health and Mental Disorders
- Preparedness and Response

CHNA & HIP

Iowa Department of Public Health

Where does Maternal and Child Health fit?

- Access to Quality Health Services: Maternal and child health providers and services
- Acute Disease: Childhood immunizations, infectious disease and prenatal care
- Addictive Behaviors: Focus on youth prevention
- Chronic Disease: Childhood diabetes and asthma
- Environmental Health: Childhood lead poisoning

CHNA & HIP

Iowa Department of Public Health

Where does Maternal and Child Health fit?

- Healthy Living: Healthy growth and development (maternal and child health, well checks), nutrition and food(includes breastfeeding), oral health, physical activity, reproductive and sexual health, youth vision and hearing
- Injury and Violence: Child safety and abuse
- Mental Health and Mental Disorders: Emotional well being, youth mental illness
- Preparedness and Response: Resource capacity and dependent or vulnerable residents

CHNA & HIP

Iowa Department of Public Health

Questions?

CHNA & HIP

Iowa Department of Public Health